State of Maryland

Reimbursement: Obstetric and Pediatric Services

On June 2, 1997, Maryland began implementing (with HCFA approval) an 1115 waiver which requires most Maryland Medicaid recipients to join a Managed Care Organization (MCOs). Pregnant women and children are key target populations under this program. Under this program, called HealthChoice, the managed care organization is responsible for providing access to all obstetrical and pediatric services.

Access standards for pregnant women and children are rigorous. For example, MCOs are required to schedule pregnant women to be seen for prenatal care within ten days of the initial request for care. In addition, MCOs are required to follow the visit requirements as outline by the American College of Obstetricians and Gynecologists. If a woman has already started her prenatal care with a out-of-network obstetrical provider before she enters the MCO, the MCO is required to pay this provider on a fee-for-service basis. This provision was placed in HealthChoice so that there would be continuity of care throughout the pregnancy and postpartum period.

Under HealthChoice, each MCO participant chooses, or is assigned, a primary medical provider (PMP), who is responsible for providing primary care services to the participant, including EPSDT well child care services for children. The PMP also either provides or refers the participant for most other needed Medicaid services.

HealthChoice was not implemented until Maryland could guarantee sufficient access to obstetrical and pediatric providers in every jurisdiction for every Medical Assistance eligible pregnant woman or child. Therefore, Maryland has already demonstrated that this population in Maryland have full access to pediatric and obstetrical care as mandated by Section 6402 of OBRA-89.

3. HMO capitation rates (paid monthly to participating HMOs for each MA eligible enrolled) are annually calculated on the basis of the fee-for-service equivalent. The fee-for-service equivalent is that amount which the Medicaid program paid on the average for recipients in defined eligibility categories for services provided during the base year. The fee-for-service equivalent, composed of payments for all services for which the HMO is responsible, is then trended forward two years to the year in which the rates will be paid. The monthly capitation rate is then determined by dividing the projected annual expenditure in an eligibility category by the number of months for which recipients were enrolled in each eligibility group. There is a rate for each eligibility group. The Maryland Medicaid HMO program provides for 20 different rates based on both federal and state eligibility categories. Ten of these rates are the result of a breakdown of AFDC by age and sex.

   Because the HMOs are liable for all Physician services as well as inpatient and outpatient hospital care, all OB and pediatric services provided at a hospital or by pediatricians, OB-GYNs, family practitioners and nurse-midwives, as well as pediatric and/or obstetrical services provided by practitioners who are enrolled as general practitioners or clinics, are included as part of the fee-for-service equivalent which is the basis of the rates paid to HMOs.

   Because all physician services (including those of nurse-midwives) as well as those of clinics and hospitals are included in the basis of the capitation rates, the program does not specify those amounts which are included in the capitation payments which were the result of OB and pediatric services.

   Program changes, such as the coverage of nurse-practitioner services beginning January 1, 1991, are factored into the trend factors used to project the expected fee-for-service expenditure.

4. Data necessary for the evaluation of compliance with Section 1902(a)(30)(A) is provided on the following chart. See next page.

Reimbursement Methodology - Early Intervention Services Case Management

1. Requests for payment of early intervention services case management shall be submitted by an approved EIS CM provider according to procedures established by the Department. The Department reserves the right to return to the EIS CM provider, before payment, all invoices not properly signed and completed.

2. The EIS CM provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;
(b) Participant's name and Medical Assistance number;
(c) Provider's name, location and provider number; and
(d Nature, unit or units, and procedure code or codes of covered services provided.

3. EIS CM providers shall bill the Medical Assistance Program for the appropriate fee as specified in # 5 (c) below.

4. The Program will make no direct payment to recipients.

5. Payment shall be made:

(a) Only to an EIS CM provider for covered services rendered to a participant, as specified in these amendments;

(b) Only to one provider of early intervention services case management rendered to a participant during a billing period; and

(c) According to the following fee-for-service schedule for early intervention services case management:

Description	Fee Per Unit of Service
1) Initial case management (Only one unit of service may be reimbursed per participant).	$500
2) Ongoing case management (Only one unit of service per month may be reimbursed for a participant, after completion of initial case management).	$150
3) Annual IFSP review (Only one unit of service may be reimbursed for a participant annually, for a total of two units per participant.)	$275

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

Reimbursement Methodology: Federally Qualified Health Centers

1. Federally Qualified Health Centers are paid 100 percent of their reasonable allowable costs that are related to the provision of covered services.

2. "Reasonable costs" are those expenses which are below 115% of the expenses allowed under section .05C of the Free-Standing Clinics regulations plus the full costs for off-site visits, outstationed eligibility workers, OB/GYN physicians, and staff who provide radiology services. For FQHCs that receive funding under Section 340 of the Public Health Service Act "reasonable costs" are those expenses which are below 140% of the expenses allowed under section .05C of the Free-Standing Clinics regulations plus the costs for off-site visits, outstationed eligibility workers, OB/GYN physicians, and staff who provide radiology services. For FQHCs that during a year perform more than 200 initial health screens for children in out-of-home placements referred by the Department of Human Resources, "reasonable costs" for expenses for these initial health screens are not limited by section .05C of the Free-Standing Clinic Regulations.

3. Reimbursement is provided on a per visit basis, with one rate for primary care services and one rate for dental care services.

4. Providers will receive an interim per visit rate prior to the start of the cost reporting year, with a final per visit rate being determined after undergoing an audit of actual expenditures for that year.

5. The interim and final per visit rates for each service are determined by dividing the provider's allowable costs for each service by the total number of visits to the provider for each service.

6. The interim per visit rates are based on the provider's actual costs for the fiscal year end which falls in the calendar year immediately preceding the year in which the rate year begins and other data available to the Department.

7. For both the interim and final per visit rates, each year the Medical Assistance Program will set maximum reimbursement rates for primary care and dental care services.

8. In calculating the rate from the cost report, the amount of non-direct care costs that are eligible for reimbursement is the lesser of the actual costs shown on the cost report or the amount that results from multiplying the provider's total cost by 33.33 percent.

9. For both services, providers will be grouped as urban or rural centers. Within each grouping and for each service, providers will be ranked from the lowest to the highest cost per visit. This ranking will be done after each provider's rate, as determined by the cost report, has been indexed forward to a common date.

10. Using the actual number of Maryland Medicaid reimbursed visits, the Program will calculate the median Maryland Medicaid cost per visit for primary care and dental services for urban and rural providers.

11. The Program's rate will be no more than 115% of the median cost for each type of service, except that for providers to whom the Public Health Service has granted funds under section 340 of the Public Health Service Act, the rate ceiling for primary care services equals 140% of the primary care rate that is associated with the 50th percentile of the paid Medical Assistance visits. For FQHCs that during a year perform more than 200 initial health screens for children in out-of-home placements referred by the Department of Human Resources, the rate ceiling does not apply for the cost of these initial health screens.

12. However, the direct costs for off-site visits, for OB/GYN physicians (salaries and fringe benefits, including any malpractice insurance for physicians that is paid by the center), for all radiology staff, and for outstationed eligibility workers are not included in costs that are limited by the primary care ceiling.

13. The costs for off-site visits, for OB/GYN physicians, and radiology staff will be spread over all primary care visits and will be added to the rate that is limited by the ceiling. The costs for outstationed eligiblity workers will be spread over Medicaid primary care visits and will be added to the rate that is limited by the ceiling. The resulting rate will be what the Medical Assistance Program will reimburse the center for each primary care visit.

14. Each provider shall submit a cost report within 3 months after the close of each provider's fiscal year.

15. Allowable costs will be determined in accordance with Medicare principles of reasonable cost reimbursement as contained in 42CFR 413.

16. Each provider shall be notified of the results of the verification of the provider's cost report.

17. The provider may appeal the final cost settlement by following the procedures described in COMAR 10.09.36.09.

Reimbursement Methodology - Ambulatory Surgical Centers

Ambulatory Surgical Centers are reimbursed a facility fee equal to 100% of the current HCFA-approved Medicare prospective rate.

Reimbursement Methodology - Mental Health Case Management

1. Requests for payment of Mental Health Case Management services shall be submitted by an approved provider according to procedures established by the Department. The Department reserves the right to return to the provider, before payment, all invoices not properly signed and completed.

2. The provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;
(b) Participant's name and Medical Assistance number;
(c) Provider's name, location, and provider number; and
(d) Nature, unit or units, and procedure code or codes of covered services provided.

3. The provider shall bill the Program for the appropriate fee or fees specified in #6.

4. The Program will make no direct payment to recipients.

5. Billing time limitations for services covered under this chapter shall be the same as those set forth in COMAR 10.09.36. General Medical Assistance Provider Participation Criteria.

6. Payment shall be made:

(a) Only to a qualified provider for covered services rendered to a participant; and

(b) According to the following fee-for-service schedule for Mental Health Case Management services:

Description	Fee Per Unit of Service
(1) Assessment or reassessment (Only one unit of service may be reimbursed annually per participant.)	$205
(2) Ongoing case management (Only one unit of service may be reimbursed for each participant during a calendar month. However, it may be reimbursed for the same date of service as an assessment or reassessment. A unit of service may not be billed before the end of the month of service and until all of the covered services have been performed as specified.	$205

7. Reimbursement may not be made for Mental Health Case Management services, if the participant is receiving a similar case management service under another Medical Assistance Program authority.

Reimbursement Methodology for EPSDT Diagnostic and Treatment Related Services

A. Request for Payment.

(1) Requests for payment of EPSDT diagnostic and treatment services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;
(b) Participant's name and Medical Assistance number;
(c) Provider's name, location, and provider number; and
(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations.

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than 9 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within 6 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original 6 month period, or within 60 days of rejection, whichever is later.

C. The following services are covered under this section of the State Plan when referred for diagnosis or treatment as a result of a full or partial EPSDT screen:

Medical or other remedial care provided by licensed practitioners (this includes chiropractic services delivered by a licensed chiropractor; nutrition counseling delivered by licensed nutritionists and dietitians; mental health counseling services delivered by a licensed clinical social worker; psychological testing and mental health counseling delivered by a licensed psychologist; mental health counseling delivered by a licensed nurse psychotherapist).

Occupational therapy services delivered by licensed occupational therapists.

Speech therapy services delivered by a speech language pathologist who is licensed to practice in the jurisdiction in which services are provided or delivered by or under the direction of a speech language pathologist who has: (a) A certificate of clinical competence from the American Speech and Hearing Association, (b) Completed the equivalent educational requirements and work experience necessary for the certificate in (a) above, or (c) Completed the academic program and is acquiring supervised work experience to qualify for the certificate in (a) above.

Rehabilitative services (these services include certified outpatient alcohol and drug abuse programs, in-home therapeutic intervention programs, medical day care for medically fragile and technology dependent children, mental health counseling services delivered by psychologists certified by the Maryland State Department of Education, and therapeutic nursery programs).

Private duty nursing services delivered by licensed registered nurses and licensed practical nurses supervised by licensed registered nurses.

Targeted case management services.

Durable medical equipment or supplies not otherwise covered under the State Plan.

Inpatient psychiatric services for individuals under age 21 year with a primary diagnosis of drug or alcohol abuse (treatment is provided in intermediate care facilities which meet the federal inpatient psychiatric services requirements for individuals under 21 years as defined in 42 CFR 441.150 and are accredited by the Joint Commission on Accreditation of Healthcare Organizations).

The reimbursement for the above services provided in private provider settings will be the lower of:

(1) The provider's customary charge to the general public; or

(2) The Department's fee schedule.

The reimbursement for services delivered by school providers or local lead agencies in school-based or early intervention settings will be based on cost.

Reimbursement Methodology - Case Management for Individuals with Developmental Disability

1. Requests for payments shall be submitted by an approved provider according to procedures established by the Department. The Department reserves the right to return to the provider, before payment, all invoices not properly signed and completed.

2. The provider shall submit a request for payment on the invoice form designated by the Department. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

a. Date or dates of service;

b. Participant's name and Medical Assistance number;

c. Provider's name, location, and provider number; and

d. Nature, unit or units, and procedure code or codes of covered services provided.

3. A unit of service for the initial development of a support services plan is defined as:

a. At least one contact by a case manager with the participant or representative;

b. A completed and signed support services plan; and

c. The provision of all other necessary covered services.

4. A unit of service for ongoing case management is defined as:

a. At least one contact by a case manager in person or by telephone with the participant or representative; and

b. The provision of all other necessary covered services.

5. The provider shall bill the Program for the appropriate fee or fees specified in #8.

6. The Program will make no direct payment to recipients.

7. Billing time limitations for services shall be the same as those set forth in COMAR 10.09.36.

8. Payment shall be made:

a. Only to one qualified provider for covered services rendered on a particular date of service to a participant; and

b. According to the following fee-for-service schedule: